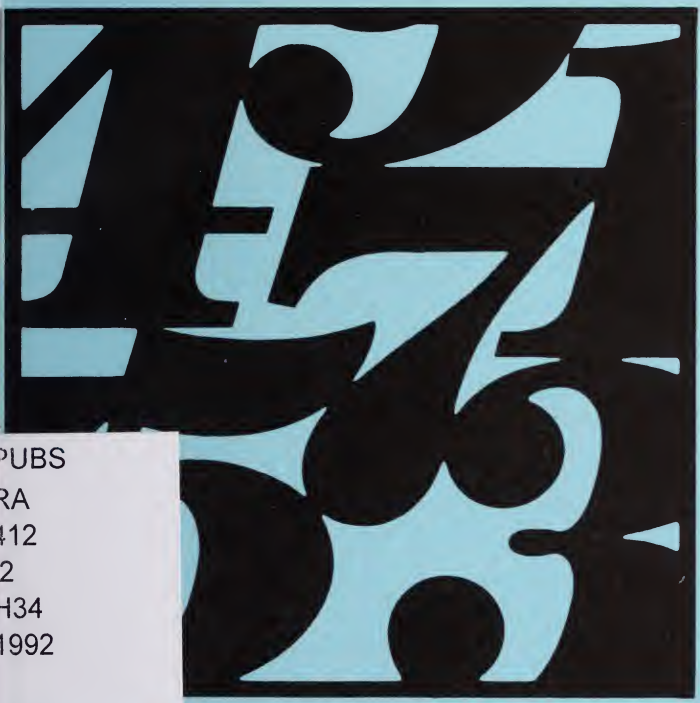
1992 HCFA Statistics



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Preface

This reference booklet provides significant summary information about health expenditures and Health Care Financing Administration (HCFA) programs. The information presented was the most current available at the time of publication. Significant time lags may occur between the end of a data year and aggregation of data for that year.

The data are organized as follows:

Highlights

Growth in HCFA programs and health expenditures

Populations

- Persons enrolled for Medicare coverage increased from 19.5 million in 1967 to a projected 35.5 million in 1992, an 82 percent increase.

- Medicaid recipients (data on eligibles are not available) increased from about 10 million in calendar year 1967 to a projected 30.1 million in fiscal year 1992, an increase of 201 percent.

Providers/Suppliers

- During the early years of the Medicare program, the number of hospitals classified as short-stay was relatively stable, in the range of 6,100-6,200. However, during 1980, the number dropped below 6,100, and by January 1992, the number decreased to 5,450.

- The total number of Medicare certified beds in short-stay hospitals showed a steady increase from less than 800,000 at the beginning of the program and peaked at 1,025,000 in 1984-86. Since that time, the number has dropped to slightly more than 965,000.

- The number of psychiatric hospitals grew to about 400 by 1976, where it remained until the start of the prospective payment system (PPS) in 1983. Since that time, the number has grown to 712.

- At the end of calendar year 1991, PPS covered 5,382 or 83 percent of all hospitals.

- The number of skilled nursing facilities (SNFs) increased rapidly during the 1960s, decreased during the first half of the 1970s, and has been increasing ever since, reaching 10,060 by the beginning of 1992.

- After peaking in 1970, the number of home health agencies (HHAs) remained stable during most of the decade. The number of HHAs accelerated with the passage of the Omnibus Budget Reconciliation Act of 1980, which permitted the certification of proprietary HHAs in States not having licensure laws. By 1986, there were almost 6,000 participating facilities. There are currently 5,963 participating facilities.

- Independent laboratories increased 219 percent from 2,355 in January 1968 to 7,509 in January 1992.

Expenditures

- National health expenditures were $51 billion in 1967, 6.3 percent of the gross national product (GNP). By 1992, expenditures are projected to reach $809 billion, 13.4 percent of GNP.

- Public expenditures on health amounted to $19 billion in 1967, 37 percent of total health expenditures. Public health expenditures are projected to reach $352 billion in 1992, 44 percent of total health expenditures.

- Federal health expenditures were 23 percent of all health expenditures in 1967 ($12 billion) and are projected to reach 29 percent in 1992 ($239 billion).

- National health expenditures per person were $247 in 1967 and are projected to reach $3,057 in 1992.

- National health expenditures are projected to reach $1,616 billion in the year 2000, representing 16.4 percent of the GNP.

Utilization of Medicare and Medicaid services

- About 55 million persons are projected to receive services paid by Medicare or Medicaid in fiscal year 1992.

- One out of five, or more than 11 million persons, will use inpatient hospital services covered by Medicare or Medicaid during 1992.

- Over four out of five, or about 46 million persons, are projected to receive reimbursable physician services under Medicare or Medicaid during 1992.

- About 29 million persons are projected to receive reimbursable outpatient hospital services under Medicare or Medicaid during 1992.

- Over 600,000 persons are projected to receive care in SNFs covered by Medicare during 1992.

- Over 1.5 million persons are projected to receive care in nursing facilities, which include SNFs and all other intermediate care facilities other than mentally retarded, covered by Medicaid during 1992.

- Over 2.8 million persons are projected to receive reimbursable HHA visits under Medicare or Medicaid during 1992.

- Nearly 20 million persons are projected to receive prescribed drugs under Medicaid during 1992.

I

Populations

Information about persons covered by Medicare or Medicaid

For Medicare, statistics are based on persons enrolled for coverage. For Medicaid, recipient counts are used as a surrogate of persons eligible for coverage, as well as for persons utilizing services. Statistics are available by major program categories, by demographic and geographic variables, and as proportions of the U.S. population. Utilization data organized by persons served may be found in the Utilization section.

Table 1
Medicare enrollment/trends

	Total persons	Aged persons	Disabled persons
		In millions	
July			
1966	19.1	19.1	—
1970	20.5	20.5	—
1975	25.0	22.8	2.2
1980	28.5	25.5	3.0
1985	31.1	28.2	2.9
1986	31.7	28.8	3.0
1987	32.4	29.4	3.0
1988	33.0	29.9	3.1
1989	33.6	30.4	3.2
1990	34.2	30.9	3.3
1991	34.9	31.5	3.4
1992[1]	35.5	31.9	3.5
1993[1]	36.2	32.4	3.8

[1]Estimated.

NOTE: Numbers may not add to totals because of rounding.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System and the Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Table 2
Medicare enrollment/coverage

	HI and/or SMI	HI	SMI	HI and SMI	HI only	SMI only
			In millions			
All persons	34.9	34.4	33.2	32.8	1.6	0.4
Aged persons	31.5	31.0	30.2	29.7	1.3	0.4
Disabled persons	3.4	3.4	3.1	3.1	0.3	([1])

[1]Number less than 50,000.

NOTES: Data as of July 1991. HI is hospital insurance. SMI is supplementary medical insurance.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 3
Medicare enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	34,870	14,761	20,109
Aged	31,485	12,650	18,835
65-74 years	17,853	7,864	9,989
75-84 years	10,239	3,852	6,387
85 years and over	3,393	934	2,459
Disabled	3,385	2,111	1,274
Under 45 years	1,206	773	433
45-54 years	790	494	297
55-64 years	1,389	845	544
White	29,728	12,554	17,174
Other races	4,014	1,739	2,274
Unknown	1,129	468	660

NOTES: Data as of July 1991. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 4
Medicare enrollment/end stage renal disease trends

	HI and/or SMI	HI	SMI
July			
1980	66,741	66,254	64,896
1981	72,807	72,344	70,786
1982	76,117	75,707	73,705
1983	89,427	88,847	86,868
1984	97,780	97,080	94,620
1985	103,997	103,171	100,694
1986	120,060	118,946	116,093
1987	130,939	129,657	126,003
1988	141,300	139,958	135,687
1989	155,231	153,813	148,155
1990	172,078	170,629	163,708
1991	191,773	190,261	182,415

NOTES: HI is hospital insurance. SMI is supplementary medical insurance.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the ESRD Program Management and Medical Information System.

Table 5
Medicare enrollment/end stage renal disease demographics

	Number of enrollees
All persons	191,773
Age	
Under 25 years	7,555
25-44 years	46,796
45-64 years	67,146
65 years and over	70,276
Sex	
Male	104,240
Female	87,533
Race	
White	113,925
Other	71,474
Unknown	6,374

NOTE: Data as of July 1991.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 6
Medicare/health maintenance organizations (HMOs)

	Number of Plans	Enrollees in thousands
Total prepaid	170	2,191
HCPPs/GPPPs[1]	52	626
Total HMOs	118	1,564
TEFRA risk	89	1,409
Cost basis	25	135
Demonstrations	4	21

[1]Health care prepayment plans/group practice prepayment plans.

NOTES: Data as of March 1992. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of Prepaid Health Care Operations and Oversight.

Table 7
Medicare enrollment/HCFA region

	Resident[1] population	Medicare[2] enrollees	Enrollees as percent of population
	In thousands		
All regions	252,424	[3]34,598	13.7
Boston	13,207	1,918	14.5
New York	29,344	4,082	13.9
Philadelphia	25,917	3,760	14.5
Atlanta	44,708	6,737	15.1
Chicago	46,384	6,476	14.0
Dallas	28,218	3,454	12.2
Kansas City	11,950	1,861	15.6
Denver	7,605	920	12.2
San Francisco	35,825	4,152	11.6
Seattle	9,266	1,225	13.2

[1]The population estimates shown here are based on the April 1, 1990 population as enumerated in the 1990 census.
[2]Medicare enrollment data are as of July 1, 1991.
[3]Includes enrollees with unknown State of residence, but excludes those living in foreign countries.

NOTE: Numbers may not add to totals because of rounding.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.
U.S. Bureau of the Census, Population Division, Population Estimates Branch.

Table 8
Aged population/projected

	1995	2000	2025	2050	2075
			In millions		
65 years and over	34.1	35.2	60.7	72.2	81.5
75 years and over	15.0	16.7	25.1	38.2	44.9
85 years and over	3.8	4.4	6.4	14.6	16.8

SOURCE: Social Security Administration, Office of Programs: Data from the Office of the Actuary.

Table 9
Life expectancy at age 65/trends

	Male	Female
Year	In years	
1965	12.9	16.3
1980	14.0	18.4
1985	14.4	18.6
1986	14.5	18.7
1987	14.6	18.7
1988	14.6	18.7
1989	14.8	18.9
1990	14.8	18.8
1991	14.9	18.9
1992[1]	14.9	19.0

[1]Estimated.

SOURCE: Social Security Administration, Office of Programs: Data from the Office of the Actuary.

Table 10
Elderly persons living below poverty level/trends

	Persons in millions	Percent
Year		
1966	5.1	28.5
1970	4.8	24.6
1980	3.9	15.7
1983	3.6	13.8
1984	3.3	12.4
1985	3.5	12.6
1986	3.5	12.4
1987	3.6	12.5
1988	3.5	12.0
1989	3.4	11.4
1990	3.7	12.2

NOTES: Beginning in 1983, income estimates used for determining poverty level were based on improved measurement of interest income. Income estimates beginning 1987 are based on revised methodology.

SOURCE: U.S. Bureau of the Census: Poverty in the United States: 1990. *Current Population Reports*. Series P-60, No. 175. Washington. U.S. Government Printing Office, 1991.

Table 11
Medicaid recipients/trends

	Fiscal year					
	1975	1980	1985	1991	1992[1]	1993[1]
	In millions					
Total[2]	22.0	21.6	21.8	28.2	30.1	31.5
Age 65 years and over	3.6	3.4	3.1	3.4	3.8	3.9
Blind/disabled	2.5	2.9	3.0	4.1	4.4	4.7
Dependent children under 21 years of age	9.6	9.3	9.8	13.0	14.0	14.7
Adults in families with dependent children	4.5	4.9	5.5	6.8	6.9	7.1
Other Title XIX	1.8	1.5	1.2	0.9	1.8	1.9

[1]Estimated.
[2]Eligibility categories may not add to totals as some recipients are classified in more than one category during the year.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics and the Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Table 12
Medicaid recipients/State buy-ins for Medicare[1]

	1975	1980	1985	1991
	In thousands			
All buy-ins	2,846	2,954	2,670	3,520
Aged	2,483	2,449	2,164	2,648
Disabled	363	504	505	871
	Percent of SMI enrollees			
All buy-ins	12.0	10.9	9.0	10.6
Aged	11.4	10.0	8.0	8.8
Disabled	18.7	18.9	19.2	28.6

[1]Recipients for whom the State paid Medicare supplementary medical insurance (SMI) premium for month of July. Number of SMI enrollees includes those with unknown state of residence, but excludes those living in foreign countries.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Entitlement Requirements.

Table 13
Medicaid recipients/demographics

	Fiscal year 1991 Medicaid recipients in millions	Percent distribution
Total recipients	28.2	100.0
Age	28.2	100.0
Under 6 years	6.6	23.4
6-20 years	7.2	25.5
21-64 years	8.8	31.2
65 years and over	3.9	13.8
Unknown	1.7	6.0
Sex	28.2	100.0
Male	9.6	34.0
Female	16.9	59.9
Unknown	1.7	6.0
Race	28.2	100.0
White	12.8	45.4
Other	11.5	40.8
Unknown	3.9	13.8

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Table 14
Medicaid recipients/HCFA region

	Resident[1] population	Medicaid[2] recipients	Recipients as percent of population
	In thousands		
All regions	[3]248,759	28,241	11.4
Boston	13,207	1,368	10.4
New York	29,344	4,289	14.6
Philadelphia	25,917	2,516	9.7
Atlanta	44,708	5,133	11.5
Chicago	46,384	4,809	10.4
Dallas	28,218	3,118	11.0
Kansas City	11,950	1,108	9.3
Denver	7,605	563	7.4
San Francisco	[3]32,160	4,483	13.9
Seattle	9,266	855	9.2

[1]The population estimates shown are based on the April 1, 1990 population as enumerated in the 1990 census.
[2]Medicaid recipient data are as of fiscal year 1991.
[3]Excludes Arizona which operates a medical assistance program under a Section 1115 demonstration project.

NOTE: Numbers may not add to totals because of rounding.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics. U.S. Bureau of the Census, Population Division, Population Estimates Branch.

II

Providers /Suppliers

Information about institutions, agencies, or professionals who provide health care services and individuals or organizationswho furnish health care equipment or supplies

These data are distributed by major provider/supplier categories, by geographic region, and by type of program participation. Utilization data organized by type of provider/supplier may be found in the Utilization section.

Table 15
Inpatient hospitals/trends

	1975	1980	1991	1992
Total hospitals	6,707	6,780	6,522	6,471
Beds in thousands	1,132	1,152	1,105	1,102
Beds per 1,000 enrollees	51.5	46.9	36.6	35.5
Short-stay	6,084	6,111	5,549	5,450
Beds in thousands	884	988	970	965
Beds per 1,000 enrollees	40.2	40.2	32.1	31.1
Psychiatric	358	408	674	712
Beds in thousands	207	136	99	99
Beds per 1,000 enrollees	9.4	5.5	3.3	3.2
Other long-stay	265	261	299	309
Beds in thousands	42	29	35	38
Beds per 1,000 enrollees	1.9	1.2	1.2	1.2

NOTES: Facility data as of January 1. Facility data exclude Christian science. Rates based on number of aged hospital insurance enrollees. Rates for 1992 based on July 1, 1991 enrollment excluding foreign countries. Facilities certified for Medicare are deemed to meet Medicaid standards.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System and Office of Research and Demonstrations. Data from the Division of Program Studies.

Table 16
Medicare assigned claims/HCFA region

	Net assignment rates		
	1980	1990	1991
All regions	51.5	81.1	83.1
Boston	67.4	91.6	93.2
New York	51.8	83.0	84.6
Philadelphia	61.6	86.4	88.0
Atlanta	52.3	82.5	84.8
Chicago	47.6	79.1	80.6
Dallas	50.3	77.6	79.8
Kansas City	40.4	72.6	74.8
Denver	39.5	65.4	69.2
San Francisco	53.2	83.3	85.1
Seattle	31.3	62.2	64.7

NOTE: Calendar year data.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Analysis.

Table 17
Hospitals and units/status under the prospective payment system (PPS)[1]

Total hospitals	6,498
Hospitals under PPS	5,383
Hospitals receiving special consideration:[2]	1,371
Regional referral centers	235
Sole community hospitals	630
Medicare dependent small rural hospitals	506
Non-PPS hospitals	1,115
Categorically exempt:	1,045
Psychiatric	714
All other non short-stay	331
Short-stay hospitals in waiver States or demonstrations[2]	57
Short-stay hospitals in outlying areas[2]	4
Cancer hospitals[2]	9
Total excluded units	1,893
Psychiatric	1,192
Rehabilitation	701

[1] PPS is a reimbursement system wherby Medicare payment for inpatient operating costs is made at a predetermined specific rate for each discharge rather than on a reasonable-cost basis, beginning on or after October 1, 1983. All discharges are classified according to a list of diagnosis-related groups.
[2] Data as of January 1992.

NOTE: Data as of March 1992.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System; Bureau of Policy Development: Division of Hospital Payment Policy; and the Health Standards and Quality Bureau: Data from the Division of Systems Management and Data Analysis.

Table 18
Long-term facilities/HCFA region

	Title XVIII and XVIII/XIX SNFs[1]	Title XIX-only SNFs	ICFs[2]	IMRs[3]
All regions	10,060	1,348	4,498	6,264
Boston	728	25	397	383
New York	813	77	49	1,082
Philadelphia	1,068	33	269	446
Atlanta	1,844	289	214	510
Chicago	2,250	343	1,079	1,988
Dallas	660	122	1,430	1,034
Kansas City	511	139	951	142
Denver	450	168	3	115
San Francisco	1,345	126	40	471
Seattle	391	26	66	93

[1]Skilled nursing facilities.
[2]Intermediate care facilities.
[3]Institutions for mentally retarded.

NOTE: Data as of January 1992.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Division of Program Studies.

Table 19
Other Medicare providers and suppliers/trends

	1975	1980	1991	1992
Home health agencies	2,254	2,858	5,730	5,963
Independent laboratories	2,994	3,448	4,881	[1]7,509
End stage renal disease facilities	—	975	2,072	2,211
Outpatient physical therapy	115	386	1,195	1,350
Portable X-ray	131	210	443	468
Rural health clinics	—	359	551	790
Comprehensive outpatient rehabilitation facilities	—	—	186	201
Ambulatory surgical centers	—	—	1,199	1,407
Hospices	—	—	825	1,108

[1]Includes providers newly covered under the Clinical Laboratory Improvement Amendment of 1988, provision effective 1992.

NOTE: Data as of January.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Division of Program Studies.

Table 20
Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	5,450	10,060	5,963
		Percent of total	
Nonprofit	57.3	27.6	39.0
Proprietary	13.4	66.1	38.4
Government	29.3	6.3	22.6

NOTES: Data as of January 1992. Facilities certified for Medicare are deemed to meet Medicaid standards.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Division of Program Studies.

Table 21
Periodic interim payment (PIP) facilities/trends

	1980	1985	1991	1992[1]
Hospitals				
Number of PIP	2,276	3,242	1, 320	1,318
Percent of total participating	33.8	48.3	20.3	20.3
Skilled nursing facilities				
Number of PIP	203	224	901	897
Percent of total participating	3.9	3.4	9.2	8.9
Home health agencies				
Number of PIP	481	931	1,295	1,301
Percent of total participating	16.0	16.0	22.0	21.8

[1]Data as of the 1st quarter of fiscal year 1992.

NOTES: Data from 1985 to 1991 are as of September; prior years are as of December. The Omnibus Budget Reconciliation Act of 1986 eliminated PIP for many inpatient hospitals.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Analysis.

Table 22
Physicians active in patient care/trends

	1980		1985		1991	
	Number	Percent	Number	Percent	Number	Percent
Physicians	[1]361,915	100.0	[1]431,527	100.0	[2]583,229	100.0
Specialties						
Medical	105,049	29.0	132,519	30.7	132,204	22.7
Surgical	103,312	28.5	118,955	27.6	153,229	26.3
Other	96,871	26.8	117,109	27.1	196,991	33.8
General practice	56,683	15.7	62,944	14.6	100,798	17.3

[1]Non-federal physicians only.
[2]Includes physicians, doctors of osteopathy (DOs) and limited licensed practicioners (LLPs).

SOURCES: For 1980 and 1985: American Medical Association: *Physician Characteristics and Distribution in the U.S.* Chicago. 1992. 1991 data are dervived from the HCFA Unique Physician Indentification Number (UPIN) Directory.

Table 23
Physicians/HCFA region

	Physicians active in patient care	Physicians per 100,000 population
All regions	[1]583,229	231
Boston	42,769	324
New York	71,568	244
Philadelphia	69,059	266
Atlanta	92,101	206
Chicago	100,660	217
Dallas	56,052	199
Kansas City	27,250	228
Denver	15,134	199
San Francisco	82,712	231
Seattle	19,979	216

[1]Includes physicians in outlying areas , but excludes those living in foreign countries.

NOTES: Physicians as of April 1, 1991. Civilian population as of April 1990.

SOURCE: HCFA Unique Physician Identification Number (UPIN) Directory.

Table 24
Inpatient hospitals/HCFA region

	Short-stay hospitals	Beds per 1,000 enrollees	Long-stay facilities	Beds per 1,000 enrollees
All regions	5,450	31.1	1,021	4.4
Boston	226	25.9	73	6.9
New York	389	30.8	72	7.7
Philadelphia	446	27.4	114	5.3
Atlanta	1,041	40.1	188	4.0
Chicago	965	37.4	143	3.5
Dallas	805	36.8	191	5.2
Kansas City	478	35.2	51	3.3
Denver	300	33.2	47	5.8
San Francisco	572	28.8	121	3.0
Seattle	228	22.9	21	2.6

NOTES: Data as of January 1992. Rates based on number of aged hospital insurance enrollees as of July 1, 1991.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

III

Expenditures

Information about spending for health care services by Medicare, Medicaid, and in the Nation as a whole

Health care spending at the aggregate levels is distributed by source of funds, types of service, geographic area, and broad beneficiary or eligibility categories. Direct out-of-pocket, other private, and non-HCFA-related expenditures are also covered in this section. Expenditures on a per-unit-of-service level are covered in the Utilization section.

Table 25
HCFA and total Federal disbursements

	Fiscal year 1991 in billions
Gross national product (current dollars)	$5,689.0
Total Federal budget[1]	1,323.0
Percent of gross national product	(23.3)
Department of Health and Human Services[1]	485.3
Percent of Federal budget	(36.7)
HCFA budget	
Medicare benefit payments	113.9
Medicaid medical assistance payments	50.2
HCFA program management	1.9
State and local administration/training	2.4
Other administrative expenses	0.6
Peer review organizations	0.3
Total (unadjusted)	170.4
Offsetting and proprietary receipts	-12.2
Total net of offsetting and proprietary receipts[1]	158.3
Percent of Federal budget	(12.0)

[1]Includes off-budget entities, net of offsetting receipts.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of Budget and Administration: Data from the Division of Budget.

Table 26
Program benefit payments/trends

	Total	Medicare	Medicaid[1]
		In billions	
Calendar year			
1980	$61.2	$36.4	$24.8
1985	110.1	70.4	39.7
1989	159.5	100.3	59.2
1990	180.2	108.9	71.3

[1]Total medical assistance payments, Federal and State expenditures combined.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 27
Benefit outlays by program

	1967	1968	1991	1992[1]
Annually		In billions		
HCFA program outlays	$5.1	$8.4	$202	$251
Medicare	3.2	5.	114	129
HI	2.5	3.7	68	76
SMI	0.7	1.4	45	53
Medicaid	1.9	3.3	88	122
Federal share	NA	1.6	50	70
Monthly	In millions		In billions	
HCFA program outlays	$423	$702	$16.8	$20.9
Medicare	264	427	9.5	10.7
HI	209	311	5.7	6.3
SMI	55	116	3.8	4.4
Medicaid	158	275	7.3	10.2
Federal share	NA	133	4.2	5.8
Hourly	In thousands		In millions	
HCFA program outlays	$579	$962	$23.0	$28.7
Medicare	362	585	13.0	14.7
HI	286	426	7.8	8.7
SMI	76	159	5.2	6.0
Medicaid	217	377	10.0	14.0
Federal share	NA	183	5.7	8.0
Minutely		In thousands		
HCFA program outlays	$10	$16	$384	$478
Medicare	6	10	217	245
HI	5	7	130	145
SMI	1	3	86	100
Medicaid	4	6	167	233
Federal share	NA	3	95	133

[1]Estimated.

NOTES: Fiscal year data. HI is hospital insurance. SMI is supplementary medical insurance. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of Budget and Administration: Data from the Division of Budget.

Table 28
Program benefit payments/HCFA region

	Medicare[1]	Medicaid	
		Computable[2]	Net adjusted[3]
		In millions	
All regions	[4]$113,948	$91,961	$52,510
Boston	6,480	7,922	4,095
New York	14,201	19,399	9,719
Philadelphia	13,616	8,459	4,703
Atlanta	21,476	14,106	9,296
Chicago	21,515	15,314	8,684
Dallas	11,635	8,297	5,667
Kansas City	5,573	3,590	2,179
Denver	2,468	1,929	1,254
San Francisco	13,811	10,353	5,301
Seattle	3,173	2,764	1,611

[1]Distribution by region is estimated.
[2]Total medical assistance payments computable for Federal funding.
[3]Net adjusted Federal share.
[4]Excludes residence unknown and residents of foreign countries.

NOTES: Data as of fiscal year 1991. Numbers may not add to totals because of rounding.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System; Office of Budget and Administration: Data from the Division of Budget; and the Medicaid Bureau: Data from the Division of Financial Management.

Table 29
National health care/projections

	Calendar year		
	1991	1995	2000
National total in billions	$738.2	$1,072.7	$1,615.9
Percent of GNP	13.1	14.7	16.4
Per capita amount	$2,817	$3,944	$5,712
Source of funds	Percent of total		
Private	57.0	55.2	53.2
Public	43.0	44.8	46.8
Federal	29.2	30.3	32.0
State/local	13.7	14.5	14.8

NOTE: GNP is gross national product.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 30
Medicare/trust fund projections

	Fiscal year		
	1991	1992[1]	1993[1]
	In billions		
HI benefit payments[2]	$68.5	$76.1	$82.8
Aged	61.1	67.9	73.8
Disabled	7.4	8.2	9.0
SMI benefit payments	45.5	52.7	59.8
Aged	40.1	47.0	53.4
Disabled	5.3	5.7	6.4

[1]Estimated.
[2]Excludes peer review organization (PRO) expenditures.

NOTES: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of Budget and Administration: Data from the Division of Budget.

Table 31
Medicare/type of benefit

	Fiscal year 1991 benefit payments in millions[1]	Percent distribution
Total HI[2]	$68,486	100.0
Inpatient hospital	60,775	88.7
Skilled nursing facility	2,459	3.5
Home health agency	4,787	7.0
Hospice	465	0.7
Total SMI	45,456	100.0
Physician/other suppliers	31,049	68.3
Outpatient hospital	9,232	20.3
Home health agency	64	0.1
Group practice prepayment	3,411	7.5
Independent laboratory	1,700	3.7

[1]Includes the effect of regulatory items and recent legislation but not proposed law. Includes HI catastrophic benefits in fiscal year 1990.
[2]Excludes peer review organization (PRO) expenditures.

NOTES: HI is hospital insurance. SMI is supplementary medical insurance. Numbers may not add to totals because of rounding. Benefits by type of service are estimated and are subject to change.

SOURCE: Health Care Financing Administration, Office of the Budget and Administration: Data from the Division of Budget.

Table 32
Medicaid/type of service

	Fiscal year	
	1990	1991
	In billions	
Total vendor payments	$64.9	$76.9
	Percent of total	
Inpatient services	28.3	28.1
General hospitals	25.7	25.5
Mental hospitals	2.6	2.6
Nursing facility services[1]	27.3	27.0
Intermediate care facility (MR) services[2]	11.3	10.0
Physician services	6.2	6.5
Dental services	0.9	0.9
Other practitioner services	0.6	0.6
Outpatient hospital services	5.1	5.5
Clinic services	2.6	2.9
Laboratory and radiological services	1.1	1.2
Home health services	5.2	5.3
Prescribed drugs	6.8	7.1
Family planning services	0.4	0.5
Early and periodic screening	0.3	0.4
Rural health clinic services	0.1	0.1
Other care	3.7	3.9

[1]Nursing facilities includes: SNFs and all other category for ICF, other than "MR".
[2]"MR" indicates mentally retarded.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Table 33
Medicaid/payments by eligibility status

	Fiscal year 1991 vendor payments in millions	Percent distribution
Total	$76,935	100.0
Age 65 years and over	25,430	33.1
Blind/disabled	28,235	36.7
Dependent children under 21 years of age	11,605	15.1
Adults in families with dependent children	10,416	13.5
Other Title XIX	1,029	1.3

NOTE: Numbers may not add to totals due to the exclusion of unknowns and because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Table 34
National health care/trends

	Calendar year			
	1965	1980	1991[1]	1992[1]
National total in billions	$41.6	$250.1	$738.2	$809.0
Percent of GNP[2]	5.9	9.2	13.1	13.4
Per capita amount	$204	$1,063	$2,817	$3,057
Source of funds		Percent of total		
Private	75.3	58.0	57.0	56.5
Public	24.7	42.0	43.0	43.5
Federal	11.6	28.8	29.2	29.5
State/local	13.2	13.3	13.7	13.9

[1]Projected.

[2]GNP is gross national product.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 35
National health care/type of expenditure[1]

	National total in billions	Per capita amount	Private as a percent of total	Public
Total	$809.0	$3,057	56.5	43.5
Health services and supplies	783.8	2,962	57.1	42.9
Personal health care	716.7	2,708	57.6	42.4
Hospital care	313.9	1,186	44.8	55.2
Physicians' services	165.5	625	65.9	34.1
Nursing home care	64.9	245	46.8	53.2
Other personal care	172.4	651	77.0	23.0
Other services and supplies	67.1	254	74.9	25.1
Research and construction	25.2	95	40.5	59.5

[1]Projected for calendar year 1992.

NOTE: Data to reflect calendar year 1992.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 36
Personal health care/payment source

	Calendar year			
	1970	1980	1991[1]	1992[1]
	In billions			
Total	$64.9	$218.3	$651.1	$716.7
	Percent			
Total	100.0	100.0	100.0	100.0
Private	65.4	60.1	58.1	57.6
Out-of-pocket	39.5	26.8	22.7	22.3
Other private	26.0	33.2	35.4	35.3
Public	34.6	39.7	41.9	42.4
Federal	11.1	16.6	30.2	30.5
State and Local	7.8	11.3	11.6	11.9

[1]Projected.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

IV

Utilization

Information about the use of health care services

Utilization information is organized by persons receiving services and alternately by services rendered. Measures of health care usage include: persons served, units of service (e.g., discharges, days of care, etc.), and dimensions of the services rendered (e.g., average length of stay, charge per person or per unit of service). These utilization measures are aggregated by program coverage categories, provider characteristics, type of service, and demographic and geographic variables.

Table 37
Medicare/short-stay hospital utilization

	1988	1989	1990
Discharges[1]			
Total in millions[2]	10.4	10.3	10.5
Rate per 1,000 enrollees	324	315	314
Days of care			
Total in millions	90	91	94
Rate per 1,000 enrollees	2,912	2,842	2,811
Average length of stay per discharge	9.0	9.0	9.0
Total charges per day	$830	$954	$1,071

[1]Includes admissions and transfers to excluded units within PPS hospitals.
[2]The population base excludes HI enrollees residing in foreign countries.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 38
Medicare long-term care/trends

	Skilled nursing facilities		Home health agencies	
	Persons served in thousands	Served per 1,000 enrollees	Persons served in thousands	Served per 1,000 enrollees
Calendar year				
1982	252	9	1,172	40
1983	264	9	1,338	45
1984	299	10	1,522	50
1985	315	10	1,576	51
1986	304	10	1,601	50
1987	293	9	1,575	49
1988	384	12	1,613	49
1989	[1]636	[1]19	1,721	51
1990	638	19	1,978	58

[1]Increased utilization coincident with changes enacted under the Medicare Catastrophic Coverage Act of 1988.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 39
Medicare average length of stay/trends

	Fiscal year					
	1984	1985	1988	1989	1990	1991
Total short-stay hospitals	9.1	8.7	8.9	8.9	8.9	9.1
PPS only	8.0	7.9	[2]8.6	[3]8.5	8.6	8.4
Non-PPS[1]	10.1	12.5	13.1	12.6	14.2	14.1
Excluded units	18.0	18.8	19.7	19.7	19.5	18.7

[1]Includes hospitals in waiver States, cancer hospitals, PPS excluded units, demonstration hospitals, and hospitals in outlying areas.
[2]Short-stay hospitals in Puerto Rico transitioned into PPS beginning October 1, 1987. The Rochester, New York demonstration terminated December 31, 1987. Hospitals covered by that demonstration were covered by PPS after that date.
[3]Short-stay hospitals in New Jersey transitioned into PPS on January 1, 1989.

NOTES: Short-stay hospitals in Massachusetts transitioned into PPS beginning September 1985 based on each provider's fiscal year start date. Short -stay hospitals in New York transitioned into PPS on January 1, 1986.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 40
Medicare persons served/trends

	Calendar year				
	1967	1975	1980	1985	1990
Aged persons served per 1,000 enrollees					
HI and/or SMI	367	528	638	722	802
HI	203	221	240	219	209
SMI	365	536	652	739	832
Disabled persons served per 1,000 enrollees					
HI and/or SMI	—	450	594	669	734
HI	—	219	246	228	209
SMI	—	471	634	715	804

NOTES: Includes beneficiaries of foreign countries. HI is hospital insurance. SMI is supplementary medical insurance. Persons served are those for whom Medicare Trust Fund payments were made. Based on July 1 enrollment. Rates may differ from estimates using risk- based enrollment.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 41
Medicare persons served/projections

	Fiscal year				
	1991	1992	1993	1994	1995
	In millions				
HI					
Aged					
Enrollees	30.5	31.0	31.5	32.0	32.4
Persons served	6.1	6.2	6.4	6.5	6.6
Disabled					
Enrollees	3.4	3.5	3.6	3.7	3.8
Persons served	0.7	0.7	0.7	0.8	0.8
SMI					
Aged					
Enrollees	29.9	30.4	30.9	31.3	31.7
Persons served	24.1	24.5	25.0	25.6	26.1
Disabled					
Enrollees	3.0	3.1	3.2	3.3	3.4
Persons served	2.3	2.3	2.4	2.5	2.6

NOTES: HI is hospital insurance. SMI is supplementary medical insurance. Enrollment represents actuarial estimates of average monthly enrollment during the fiscal year.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Table 42
Medicare persons served/HCFA region

	Aged persons served in thousands	Served per 1,000 enrollees	Disabled persons served in thousands	Served per 1,000 enrollees
All regions[1]	24,802	808	2,389	737
Boston	1,437	829	118	758
New York	2,928	807	282	691
Philadelphia	2,823	842	256	755
Atlanta	4,875	831	543	762
Chicago	4,730	820	447	739
Dallas	2,494	820	244	727
Kansas City	1,402	831	115	756
Denver	644	788	55	698
San Francisco	2,643	714	259	732
Seattle	825	753	71	701

[1]Excludes residents of foreign countries.

NOTES: Data as of calendar year 1990 for persons served under Hospital Insurance and/or Supplementary Medical Insurance. Based on utilization for fee-for-service and excludes utilization under alternative payment systems such as health maintenance organizations.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System.

Table 43
Medicare/end stage renal disease (ESRD)

	Calendar year	
	1990	1991[1]
Total enrollees[2]	172,078	191,773
Dialysis patients[3]	129,800	142,208
Outpatient	107,160	117,088
Home	22,640	25,120
Transplants performed[4]	9,796	9,961
Living donor	2,091	2,277
Cadaveric donor	7,705	7,599
Living Unrelated	90	85
Average dialysis payment rate		
Hospital-based facilities	$129	$130
Freestanding facilities	$125	$126

[1]Preliminary
[2]Medicare ESRD enrollees as of July 1.
[3]Includes Medicare and non-Medicare patients receiving dialysis as of December 31.
[4]Includes kidney transplants for Medicare and non-Medicare patients.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Decision Support System and the Bureau of Policy Development: Data from the Division of Special Payment Programs.

Table 44
Medicaid/type of service

	Fiscal year 1991 Medicaid recipients in thousands
Total	28,241
Inpatient services	
General hospitals	5,058
Mental hospitals	65
Nursing facility services	1,500
Intermediate care facility (MR) services	146
Physician services	19,296
Dental services	5,201
Other practitioner services	4,271
Outpatient hospital services	14,114
Clinic services	3,505
Laboratory and radiological services	10,492
Home health services	810
Prescribed drugs	19,577
Family planning services	2,144
Early and periodic screening	3,948
Rural health clinic services	404
Other care	5,946

NOTES: Nursing facilities include: SNFs and all other category for ICF, other than "MR". "MR" indicates mentally retarded.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

Table 45
Medicaid/units of service

	Fiscal year 1991 units of service in thousands
General hospital	
Total discharges	5,265
Recipients discharged	3,625
Total days of care	28,957
Nursing facility	
Total days of care	387,550
Intermediate care facility/mentally retarded	
Total days of care	50,276
Physician visits	129,064
Rural health clinic visits	1,379
Home health service visits	70,649
Drug prescriptions	377,025

NOTES: Based on reporting States. Nursing facilities include: SNFs and all other category for ICF, other than mentally retarded.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics.

V

Administrative /Operating

Information on activities and services related to oversight of the day-to-day operations of HCFA programs

Included are data on Medicare contractors, contractor activities and performance, HCFA and State agency administrative costs, quality control, and summaries of the operation of the Medicare trust funds.

Table 46
Medicare administrative expenses/trends

	Administrative expenses	
	Amount in millions	As a percent of benefit payments
HI Trust Fund		
1970	$149	3.1
1975	259	2.5
1980	497	2.1
1985	813	1.7
1987	836	1.7
1988	707	1.4
1989	805	1.4
1990	774	1.2
1991	934	1.4
SMI Trust Fund		
1970	217	11.0
1975	405	10.8
1980	593	5.8
1985	922	4.2
1987	900	3.0
1988	1,265	3.8
1989	1,450	3.9
1990	1,524	3.7
1991	1,505	3.3

NOTES: Fiscal year data. HI is hospital insurance. SMI is supplementary medical insurance.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Table 47
Medicare/contractors

	Intermediaries	Carriers
Blue Cross/Blue Shield	41	25
Other	7	8

NOTES: Data as of January 1992. Reference to intermediaries as Part A has been dropped in recognition of the fact that intermediaries also service Part B institutional bills.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Contracts.

Table 48
Medicare/appeals

	Intermediary reconsiderations	Carrier reviews
Number processed	34,092	7,396,838
Percent reversal rate[1]	47.6	63.6

[1]Excludes withdrawals and dismissals.

NOTE: Data for fiscal year 1991.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Analysis.

Table 49
Medicare/claims processing costs

	Net unit cost per claim			
	1975	1980	1985	1991
Intermediaries	$3.84	$2.96	$2.33	$1.75
Carriers	2.90	2.33	1.88	1.50

NOTE: Fiscal year data.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Contractor Financial Management.

Table 50
Medicare/claims processing

	Intermediaries	Carriers
Claims processed in millions	91.9	501.4
Total costs in millions	$445.0	$1,008.3
Claims processing costs in millions	$162.9	$595.9
Claims processing unit costs	$1.64	$1.13
Range		
High	$2.74	$1.67
Low	$1.12	$0.97

NOTE: Data for fiscal year 1991.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Contractor Financial Management.

Table 51
Medicare/claims received

	Claims received
Intermediary claims received in thousands	94,410
	Percent of total
Inpatient hospital	13.0
Outpatient hospital	54.4
Home health agency	9.4
Skilled nursing facility	1.7
Other	21.4
Carrier claims received in thousands	517,123
	Percent of total
Assigned	83.1
Unassigned	16.9

NOTE: Data as of calendar year 1991.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Analysis.

Table 52
Medicare/reasonable charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	384.2	77.5
Percent reduced	87.4	91.3
Total covered charges		
Amount in millions	$60,057	$7,884
Percent reduced	36.3	23.1
Amount reduced per claim	$56.72	$23.51

NOTE: Data as of calendar year 1991.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Analysis.

Table 53
Medicaid/administration

	Fiscal year	
	1990	1991[1]
	In thousands	
Total payments computable for Federal funding	$3,502,382	$3,852,118
Federal share of current expenditures:		
Family planning	9,334	9,891
Design, development or installation of MMIS[2]	29,784	35,471
Skilled professional medical personnel	126,024	133,427
Operation of an approved MMIS[2]	410,939	422,146
Other financial participation	1,394,338	1,533,606
Mechanized systems not approved under MMIS[2]	19,086	29,670
Total administration	1,989,505	2,164,211
Net adjusted Federal share	[3]2,004,595	N/A

[1]State estimates as submitted November 1991. Net adjusted Federal share includes cash-flow adjustments.
[2]Medicaid Management Information System.
[3]Includes Federal share of current expenditures plus State reported and Health Care Financing Administration adjustments.

NOTE: N/A indicates data are not available.

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from the Division of Financial Management.

Table 54
Quality control/Medicare Part B carriers

	Average carrier error rate			
	1977	1985	1990[1]	1991[1]
Occurrence [2]	8.7	6.4	6.1	4.6
Assigned	8.3	5.7	—	—
Unassigned	9.2	7.7	—	—
High	—	—	8.7	6.8
Medium	—	—	8.0	5.8
Low	—	—	5.5	4.5
Payment/deductible [3]	1.9	1.8	1.2	1.0
Assigned	1.8	1.7	—	—
Unassigned	2.0	1.8	—	—
High	—	—	1.1	1.1
Medium	—	—	1.4	0.9
Low	—	—	1.2	1.0

[1]As of July 1, 1989, under the revised Part B Quality Assurance System, the assigned and unassigned divisions have been eliminated. The sample is now divided into three groups, using the amount of submitted charges (high, medium, and low).

[2]Claims processing errors per 100 line items.

[3]Dollar error per $100 of submitted charges without nonreview penalty.

NOTE: Calendar year data.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Performance Evaluation.

Table 55
Quality control/Medicaid

	Eligibility national average error rate[1] in percent of dollars
Fiscal year	
1985	2.7
1986	2.5
1987	2.3
1988	2.2
1989	2.0
1990	2.0
1991[2]	2.0

[1]Excludes Supplemental Security Income determinations.
[2] Reprersents the period October 1990 through March 1991.

NOTE: Beginning in 1982, the Tax Equity and Fiscal Responsibility Act of 1982 mandated the exclusion of certain errors from the Medicaid Quality Control System, thereby lowering error rates.

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from the Division of Program Performance.

Reference

Selected reference material including cost-sharing features of the Medicare program, program financing, and Medicaid Federal medical assistance percentages

Program financing

Medicare/source of income

Hospital Insurance trust fund:
1. Payroll taxes*
2. Transfers from railroad retirement account
3. General revenue for
   a. uninsured persons
   b. military wage credits
4. Premiums from voluntary enrollees
5. Interest on investments

*Contribution rate	1991	1992	1993
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90

Calendar year 1992 maximum taxable base: $130,200

Supplementary Medical Insurance trust fund:
1. Premiums paid by or on behalf of enrollees
2. General revenue
3. Interest on investments

Medicaid/financing
1. Federal contributions (ranging from 50 to 80 percent for fiscal year 1993)
2. State contributions (ranging from 20 to 50 percent for fiscal year 1993)

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Medicare deductible and coinsurance amounts

Part A (effective date)	**Amount**
Inpatient hospital deductible (1/1/92)	$652/benefit period
Regular coinsurance days (1/1/92)	$163/day for 61st thru 90th day
Lifetime reserve days (1/1/92)	$326/day (60 nonrenewable days)
SNF coinsurance days (1/1/92)	$81.50/day for 21st thru 100th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/92)	$192/month
Limitations:	
Inpatient psychiatric hospital days	190 nonrenewable days
Part B (effective date)	**Amount**
Deductible (1/1/91)	$100 in reasonable charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance	20 percent of allowed charges
Premium (1/1/92)	$31.80/month
Limitations:	
Outpatient treatment for mental illness	No limitations
Licensed physical therapist's services in home or office (1/1/91)	$600 (80% of maximum annual program payment of $750)

SOURCE: Health Care Financing Administration, Office of Legislation and Policy: Data from the Division of Legislation.

Geographical jurisdictions of HCFA regional offices and Federal medical assistance percentages (FMAP) fiscal year 1992

I.	Boston	FMAP
	Connecticut	50
	Maine	62
	Massachusetts	50
	New Hampshire	50
	Rhode Island	53
	Vermont	61
III.	**Philadelphia**	
	Delaware	50
	District of Columbia	50
	Maryland	50
	Pennsylvania	57
	Virginia	50
	West Virginia	78
V.	**Chicago**	
	Illinois	50
	Indiana	64
	Michigan	55
	Minnesota	54
	Ohio	61
	Wisconsin	60
VII.	**Kansas City**	
	Iowa	65
	Kansas	59
	Missouri	61
	Nebraska	65
IX.	**San Francisco**	
	Arizona	63
	California	50
	Hawaii	53
	Nevada	50
	American Samoa	50
	Guam	50
	N. Mariana Islands	50
	Mexico	—

II.	New York	FMAP
	New Jersey	50
	New York	50
	Puerto Rico	50
	Virgin Islands	50
	Canada	—
IV.	**Atlanta**	
	Alabama	73
	Florida	55
	Georgia	62
	Kentucky	73
	Mississippi	80
	North Carolina	67
	South Carolina	73
	Tennessee	68
VI.	**Dallas**	
	Arkansas	76
	Louisiana	75
	New Mexico	74
	Oklahoma	71
	Texas	64
VIII.	**Denver**	
	Colorado	55
	Montana	72
	North Dakota	73
	South Dakota	73
	Utah	75
	Wyoming	69
X.	**Seattle**	
	Alaska	50
	Idaho	73
	Oregon	64
	Washington	55

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from the Division of Financial Management.

Health Care Financing Administration
Bureau of Data Management and Strategy
HCFA Pub. No. 03333 September 1992